STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185290	A. BUILDING _____ B. WING _____	08/19/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY CARE AND REHABILITATION CENTER	1550 RAYDALE DR LOUISVILLE, KY 40219

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A standard health survey was conducted on 08/17/10 - 08/19/10 and a Life Safety Code Survey was conducted on 08/18/10. Deficiencies were cited with the highest scope and severity of an "E" with the facility having the opportunity to correct the deficiencies before remedies would be recommended for imposition. During the standard health survey a complaint investigation was conducted investigating KY14421, unsubstantiated; KY14491 substantiated without regulatory violations due to a deficiency issued at 483.25 Quality of Care F309 Care and Services at a Scope and Severity of a "D"; KY14533, unsubstantiated; KY14579, unsubstantiated; KY15126, unsubstantiated.	F 000	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, **Regency Care & Rehabilitation Center** does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to follow the written comprehensive plan of care for one (1) of thirty (30) sampled residents (Resident #6) which included the use of floor mats as an intervention to prevent injury from falls. The findings include: Record review of the comprehensive care plan revealed Resident #6 had a documented risk of falls due to a history of quadriplegia, psychotropic	F 282	**F282** 1. Resident # 6 had no negative affect. On 8/19/10 resident # 6's bed bolsters were removed and floor mats were re-implemented. 2. All residents with current care plans that include the use of devices for fall prevention approaches have the potential to be affected. Resident's in this category have been observed by a nurse manager/supervisor between 9/18-9/19/10 to ascertain that falls approaches are in place. Care plans were reviewed and revised as	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

X [signature] | X Administrator | X 9/23/2010

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

RECEIVED
SEP 23 2010
OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

nn

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185290	A. BUILDING _____ B. WING _____	08/19/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY CARE AND REHABILITATION CENTER	1550 RAYDALE DR LOUISVILLE, KY 40219

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 1 medication, and behaviors. The care plan dated 04/29/10 listed an intervention for mats on the floor next to the bed. Record review of the Interdisciplinary Progress Note dated 10/27/09 at 12:00pm documented a concern related to the use of bolsters. The Interdisciplinary Team agreed to discontinue bilateral bolsters and continue with the use of floor mats. Record review of the Interdisciplinary Progress Note dated 03/17/10 at 12:10pm stated the plan was to continue the use of the bilateral fall mats. Observations of Resident #6 on 08/17/10 at 10:00am 11:15am and 3:15pm, on 08/18/10 at 8:15am, 3:45pm, and on 08/19/10 at 8:30am, 10:30am, 11:30am and 1:00pm found the resident lying in bed with bilateral bolsters on the bed without mats on the floor as stated in the care plan. Observation of Resident #6 on 08/19/10 at 11:30am revealed that bilateral bolsters were removed from the bed, and no mats were on the floor as stated in the care plan. Interview with Licensed Practical Nurse (LPN) #5 regarding Resident #6 on 08/19/10 at 1:55pm revealed he was unaware Resident #6 had bolsters or that the bolsters were removed. LPN #5 stated he usually worked on the opposite hall and when Resident #6 was on that hall last year, he had mats on the floor rather than bolsters. Interview with the Director of Nursing (DON) regarding Resident #6 on 08/19/10 at 2:15pm revealed the bolsters were removed because they	F 282	indicated by the nurse manager/supervisor on 9/18-9/19/10. 3. All nursing staff will be re-educated on following the plan of care by the Nurse Manager on or before 10/2/10. New applicable employees will receive this education during orientation from the Assistant Director of Nursing/nurse managers/supervisors. The nurse managers/supervisors were re-educated by the DNS on 9/15/10 on performing routine rounds to observe for compliance with the plan of care. 4. The nursing managers/supervisors will make rounds weekly on each shift for four weeks then monthly for two months to observe each resident to ensure compliance with plan of care. Identified problems will be rectified immediately. Results of rounds will be reported to the facility Performance Improvement Committee monthly for three months and thereafter as indicated by findings Date of Compliance is 10/3/2010 10/2/2010 MZ per admin on 9/24/10	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185290	A. BUILDING _____ B. WING _____	08/19/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY CARE AND REHABILITATION CENTER	1550 RAYDALE DR LOUISVILLE, KY 40219

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 2 should not have been on the bed. The DON reviewed the Interdisciplinary Progress Notes and stated that floor mats should have been used rather than the bilateral bolsters as stated in the care plan.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to follow physicians' orders for two (2) of thirty (30) sampled residents (Resident #9 and #12). Resident #9 did not receive oxygen at 2 liters per minute continuously by nasal cannula. Resident #12 received oxygen at a flow other than that ordered by the physician. The findings include: No policy regarding oxygen delivery was received from the facility. Observation of Resident #9 on 08/17/10 at 11:15am and 3:00pm, found no oxygen concentrator or equipment at the bedside. Record review of physician's orders for 06/21/10 indicated Resident #9 was to receive oxygen at	F 309	**F309** 1. Resident's # 9 and 12 had no negative affect. Resident #9 was assessed by a licensed nurse on 8/19/10 and 9/21/10 and determined not to require oxygen. Physician's orders were clarified on 9/21/10 and plan of care was revised on 9/21/10 to reflect that assessment. Resident #12's oxygen flow was observed by a licensed nurse on 8/19/10 and 9/21/10 and was at the level required by physician's orders. 2. All residents with oxygen orders have the potential to be affected. All residents' physician oxygen orders were reviewed by the Director of Nursing Services on 9/19/10 to identify any resident with an order for oxygen and to clarify flow rate. Residents with orders were observed by a nurse manager/ supervisor from 9/19-9/20/10 to ensure that each resident with an order was receiving oxygen at the correct flow rate. All residents with orders for oxygen were found to have the oxygen in place at the correct flow rate.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185290	A. BUILDING _____ B. WING _____	08/19/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY CARE AND REHABILITATION CENTER	1550 RAYDALE DR LOUISVILLE, KY 40219

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 3 two (2) liters per minute continuously by nasal cannula. This order was repeated on the order summary form on 07/26/10. The order for oxygen was not reflected on the June 2010, July 2010, or August 2010 Medication Administration Records (MAR) or the Treatment Administration Records (TAR). Interview with Licensed Practical Nurse (LPN) #4 on 08/18/10 at 10:30am revealed the LPN was not aware of the oxygen order and suggested the order must have been discontinued since it was not on the MAR. Interview with Resident #9 on 08/18/10 at 10:40am revealed the resident experienced an episode of shortness of breath within the last two (2) weeks and the resident would have used oxygen if it was available. Interview with LPN #1 on 08/18/10 at 11:15am who reviewed the record and discussed the oxygen order with the Director of Nursing (DON), indicated the resident would not wear the oxygen, and the DON said the oxygen order should have never been written. Interview with the DON on 08/19/10 at 3:15pm found that the order was not considered necessary. The DON stated, "we had an order we did not need, and it has been discontinued." The DON was not aware of the resident's recent complaint of shortness of breath. Observations of Resident #12 on 08/17/10 at 11:00am, 08/18/10 at 9:20am, and 08/19/10 revealed the resident had oxygen at 3 liters per minute by nasal cannula.	F 309	3. Nursing staff have been re-educated by the nurse manager/supervisor on or before 10/2/10 on the importance of following physicians' orders, including orders for oxygen therapy. New applicable employees will receive education during orientation from the Assistant Director of Nursing/nurse manager. Nursing managers/ supervisors were re-educated by the Director of Nursing Services on 9/15/10 on monitoring for compliance with provision of services according to physicians orders. 4. Nursing managers/supervisors will make rounds weekly on each shift to observe residents receiving oxygen therapy and monitor for compliance with physician's orders for oxygen therapy. Identified problems will be rectified immediately. Results of rounds will be reported to the facility Performance Improvement Committee monthly for three months and thereafter as indicated by findings. Date of Compliance is ~~10/3/2010~~ 10/2/2010 mzg	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185290	A. BUILDING _____ B. WING _____	08/19/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY CARE AND REHABILITATION CENTER	1550 RAYDALE DR LOUISVILLE, KY 40219

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 4 Record review of medical orders for Resident #12 revealed the physician had ordered oxygen at 2 liters per minute by nasal cannula. Interview with CNA #5 on 08/19/10 at 10:45am revealed she was aware that the resident was on oxygen. When asked who monitors the liter flow she stated that was the nurse's responsibility and the CNAs just make sure the nasal cannula is in place. Interview with LPN #8 on 08/19/10 at 10:50am revealed he was aware that Resident #12 received oxygen therapy. When asked what the liter flow should be, he checked the TAR and revealed the liter flow was ordered to be 2 liters/min. When asked what the liter flow for Resident #12 was actually set on he entered the room and stated the oxygen flow was set on 3 liters. He then reduced the rate to 2 liters. The LPN revealed the normal process was for each shift to check the oxygen flow and then initial the TAR indicating it had been checked.	F 309	**F363** 1. No specific residents were identified. No resident's were negatively affected.	
F 363 SS=E	483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to follow the dietician prepared therapeutic menu at dinner (served at	F 363	2. All residents have the potential to be affected. 3. All nutrition services staff were re-educated by the Nutrition Services Director (NSD) on or before 9/16/10 on how to read the therapeutic diet spreadsheets and strict adherence to items on the menu, including condiments. New applicable employees will receive this education during orientation from the NSD. The process during tray preparation has also been revised. The therapeutic	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185290	A. BUILDING _____ B. WING _____	08/19/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY CARE AND REHABILITATION CENTER	1550 RAYDALE DR LOUISVILLE, KY 40219

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 363	Continued From page 5 12:00pm) on 08/17/10 and 08/18/10. The findings include: Record review of the menus for the regular and pureed diets for 08/17/10 dinner stated: three (3) ounces chicken livers, country gravy, mashed potatoes, buttered broccoli, roll, margarine, and fruit cobbler. The alternate selection stated: beef, noodles, gravy, and squash casserole. Record review of the regular and pureed menu for 08/18/10 dinner stated: meatloaf, gravy, baked potato, green beans, bread, margarine, and fresh fruit. The alternate stated: fish, tartar sauce, french fries, and carrots. Observation of the dinner meal served on 08/17/10 at 12:25pm in the dining room, found residents were served two (2) chicken livers, gravy, mashed potatoes, either buttered broccoli or cooked zucchini, margarine and no roll. Multiple residents in the dining room did not receive fruit cobbler, and none of the residents in the dependent feeding area received a roll or cobbler. Residents who requested the alternate selection received cooked zucchini rather than squash casserole as stated on the menu. Observation of the dinner meal served on 08/18/10 at 12:10pm in the dining room, found residents were served meatloaf, gravy, baked potato (mashed for pureed diet), green beans, no bread, margarine, and fresh fruit cup. Multiple residents did not receive margarine or bread in the dining room. Residents who requested the alternate did not receive tartar sauce as stated on the menu.	F 363	diet spreadsheets are now retained at the tray line for quick reference by employees regarding menu items. Additionally, a dietary employee has now been designated to visually inspect each plated tray against the menu to ensure all applicable food and condiments are present. 4. The NSD or Dietitian will conduct a weekly tray audit of twenty trays for four weeks, then twice a month for two months to ensure menu adherence. These findings will be reported monthly through the Performance Improvement (PI) meeting to the committee for recommendations and/or suggestions. Date of Compliance ~~10/3/2010~~ 10/2/2010 mg	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185290	A. BUILDING _____ B. WING _____	08/19/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY CARE AND REHABILITATION CENTER	1550 RAYDALE DR LOUISVILLE, KY 40219

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 363	Continued From page 6 Observation of the kitchen tray line on 08/18/10 at 11:40am found that sour cream and tartar sauce were added to trays designated for delivery to the nursing units, but these condiments were not placed on trays designated for delivery to the dining room. The dietary workers stated that sour cream and tartar sauce were not placed on dining room trays because these items were available upon request in the dining room. Interview with the Dietary Director on 08/18/10 at 11:40am revealed the cook failed to prepare the bread for the dinner meal on 08/17/10. He stated that deviations from the menu plan are communicated to residents by the dining room staff as they are seated for the meal. He was not aware of multiple residents who did not receive fruit cobbler on 08/17/10. He stated that the chicken livers were served in three (3) ounce portions by means of volume measurement. Interview with Regional Director Nutritional Services (RDNS) and the Administrator on 08/19/10 at 4:00pm revealed residents were provided with an additional serving of bread at the supper meal on 08/17/10 to correct the omission from the earlier dinner meal on that day. The RDNS stated that residents are notified of changes to the menu as they enter the dining room for service and stated this is considered adequate notice. Regarding the substitution of zucchini for squash casserole on 08/17/10, the RDNS stated this was an "equal" exchange. The RDNS stated the chicken livers are measured with appropriate scoops and spoodles to provide the three (3) ounce portion. When asked if the chicken livers are weighed, he replied, "we could weigh them." Both the RDNS and Administrator agreed that all items on the menu should be	F 363		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185290	A. BUILDING _____ B. WING _____	08/19/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY CARE AND REHABILITATION CENTER	1550 RAYDALE DR LOUISVILLE, KY 40219

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 363	Continued From page 7 served on each tray.	F 363		
F 369 SS=D	483.35(g) ASSISTIVE DEVICES - EATING EQUIPMENT/UTENSILS The facility must provide special eating equipment and utensils for residents who need them. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, it was determined the facility failed to provide special eating equipment and adaptive devices for three (3) of the thirty (30) sampled residents (Residents #24, #29, and #30). Resident #24 and Resident #30 had been assessed to need adaptive utensils at each meal; however, the facility failed to provide the needed utensils. Resident #29 had been assessed and required the use of a straw with liquids. The findings include: Review of the tray card and table name card for Residents #24 and #30 at the noon meals on 08/17/10 and 08/18/10 and the evening meal on 08/19/10 revealed the residents required adaptive utensils at each meal. Observation of those three meals revealed Residents #24 and #30 received regular utensils. Interview with Certified Nursing Assistant (CNA) #4 and CNA #2 revealed they were aware the symbols on the name cards on the tables had a meaning, but neither one could report the meaning of the symbols. CNA #4 did ask the dietary manager and he gave her a book with the meaning of the symbols explained.	F 369	**F369** 1. Resident's # 24, 29 and 30 had no negative affect. The tray cards for residents #24, 29 and 30 were verified by the NSD to ensure adherence to the doctor's order regarding required adaptive feeding equipment on 9/15/10. NSD also verified all required equipment was present and available on 9/15/10. 2. All residents with adaptive equipment have the potential to be affected. The NSD reviewed all residents on or before 9/15/10 with orders for adaptive equipment and verified tray cards corresponded and such equipment was present. 3. The NSD re-educated all nutrition staff on or before 9/16/10 on reading the tray cards, including location where adaptive equipment is indicated. NSD revised the location of the list of residents with adaptive equipment to be located next to tray line for immediate reference. All new applicable employees will receive this education during orientation from the NSD.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185290	A. BUILDING _____ B. WING _____	08/19/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY CARE AND REHABILITATION CENTER	1550 RAYDALE DR LOUISVILLE, KY 40219

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 369	Continued From page 8 Interview with the Dietary Director on 08/19/10 at 3:30pm revealed adaptive devices for residents are listed on both the dietary card and name card at each table. Observation on 08/18/10 at 12:15pm and at 12:31pm of Resident #29 revealed the resident was served a puree house diet lunch tray with the specific instructions on the diet card to give a straw for the drinks on the meal tray. The meal tray was not served with a straw, nor did any staff provide a straw during the meal. The resident was fed his/her meal service by Licensed Practical Nurse (LPN) #3, the LPN was observed to pick up the resident's drink and place the cup to the resident's mouth and the resident would tilt their head back while drinking. The resident was observed to experience coughing episodes after he/she drank liquids from the cup. Interview with LPN #3 on 08/18/10 at 12:45pm revealed there was not a straw served on the tray with the resident's meal during meal service. The LPN reported this resident frequently drinks without a straw and she/he just did not get one for the resident's use.	F 369	4. The NSD or Dietitian will conduct a weekly tray audit of twenty trays for four weeks, then twice a month for two months to ensure tray card adherence. These findings will be reported monthly through the Performance Improvement (PI) meeting to the committee for recommendations and/or suggestions. Date of Compliance ~~10/3/2010~~ 10/2/2010 MZ **F371** 1. No specific residents were identified. No resident was negatively affected. 2. All residents have the potential to be affected. Ice build-up in walk-in freezer was removed by the Maintenance Director on 8/21/10. All items in the walk-in freezer were examined by the NSD from 8/21-8/25/10 to ensure proper labeling of date opened, use-by date and product type were present; including appropriate storage method for each food item.	
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185290	A. BUILDING _____ B. WING _____	08/19/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY CARE AND REHABILITATION CENTER	1550 RAYDALE DR LOUISVILLE, KY 40219

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 9 This REQUIREMENT is not met as evidenced by:. Based on observation, interview, and record review, it was determined the facility failed to store food under sanitary conditions as evidenced by multiple opened and undated food items identified in the freezer and ice found on the ceiling of the freezer extending to the shelf below where ice formed on a frozen food product. The findings include: Upon record review, the facility policy regarding cold food storage states; the Nutrition Service Director/Cook is responsible to ensure all food items are stored properly in covered containers, labeled, and dated. Observation during the initial tour on 08/18/10 at 8:10am of the kitchen revealed multiple frozen food products previously opened which were unsealed and unlabeled. The open and unlabeled items found in the freezer include: one (1) box butter egg dinner rolls, one (1) box strawberries, one (1) box diced potatoes, one (1) box Sysco corn on the cob, one (1) box Sysco kernel corn, one (1) box Sysco peas, one (1) box chicken livers, and one (1) box individual pizzas. Continued observation during the initial tour of the kitchen revealed a formation of ice on the ceiling of the freezer which extended to the top shelf and ice formed inside a frozen pie shell directly under the ice formation. Interview with Dietary Director on 08/18/10 at 11:40am revealed that all previously opened frozen foods should be resealed and dated. The	F 371	3. All nutrition staff were re-educated by the NSD on or before 9/16/10 on proper labeling and storage requirements for all food items; including date opened, use-by date and type of product. Education also included proper storage method to prevent spoilage. New applicable employees will receive education during orientation by the NSD. The maintenance director inspected walk-in freezer on 8/21/10 to ensure optimal operation. Inspection determined ice build-up was not secondary to mechanical malfunction. 4. The NSD or Dietitian will conduct a weekly sanitation audit for four weeks, then twice a month for two months. These findings will be reported monthly through the Performance Improvement (PI) meeting to the committee for recommendations and/or suggestions. Date of Compliance ~~10/3/2010~~ 10/2/2010 MG	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185290	A. BUILDING _____ B. WING _____	08/19/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY CARE AND REHABILITATION CENTER	1550 RAYDALE DR LOUISVILLE, KY 40219

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 10 Dietary Director was not aware of the ice accumulation currently in the freezer, though ice accumulation was recognized to present a risk of cross-contamination. Interview with Regional Director of Nutritional Services and the Administrator on 08/19/10 at 4:00pm revealed that both agreed that frozen foods should be resealed and dated after being opened.	F 371		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to provide housekeeping and maintenance services necessary to maintain low air loss mattresses in a sanitary manner and clean bedding for five (5) of thirty (30) sampled residents (Residents #2, #12, #25, #26, and #27). The findings include: Observation of Resident #2's low air loss mattresses on 08/19/10 at 10:30am revealed a tan colored dried substance caked in the creases of the dark blue mattress cover with tan and white loose particles in the bed. This resident had a white towel wrapped around the connection of the gastric tube and the feeding tube placed on the resident's abdomen.	F 465	**F465** 1. Resident's # 2, 12, 25, 26 and 27 had no negative affect. Dark blue mattress covers for residents #2, 12, 25, 26 and 27 were changed on 8/19/2010. 2. Each resident with a low air loss mattress has the potential to be affected. The nursing manager/supervisor on 9/18-9/19/10 observed all residents with low air loss mattresses to ensure that the each mattress cover was clean. No residents were identified with unclean mattress covers. 3. Facility has put into place procedure for changing low air loss mattress covers on resident's shower days and prn. Additional low air loss mattress covers were purchased on 9/15/2010 by facility. All nursing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185290	A. BUILDING _____ B. WING _____	08/19/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY CARE AND REHABILITATION CENTER	1550 RAYDALE DR LOUISVILLE, KY 40219

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 465	Continued From page 11 Observation of Residents #12, #25, #26, and #27's low air loss mattresses on 08/19/10 at 11:30am revealed loose particles, and spots of dried white and brown substances on the dark blue bed surface that the resident laid on. Interview with Certified Nurse Assistant (CNA) #3 on 08/19/10 at 10:30am revealed the low air loss mattresses were cleaned while the residents were in the shower. The CNA reported the gastric tube sometimes leaks and gets on Resident #2's mattress. The CNA reported the mattress is sprayed down with a spray that Housekeeping has on their carts; however, the CNA was not able to provide the name of the solution used to clean the beds. The CNA reported the mattress cover on the bed was the only cover for the bed because there are no other covers that the CNA was aware of in the facility for this type of bed. Interview with Licensed Practical Nurse (LPN) #8 on 08/19/10 at 10:32am revealed the dark blue mattress cover for the low air loss mattresses are kept on the West Hall for replacement while they are washed in the laundry department. The LPN reported she would go and get a clean mattress cover for Resident #2's bed. The LPN returned to Resident #2's room and reported the mattress covers are now kept on North Hall and preceded to North Hall to obtain a mattress cover.	F 465	staff have been re-educated by nurse manager/supervisor on or before 10/2/2010 on new procedure, including location of replacement mattress covers. New applicable employees will receive education during orientation by nurse manager/supervisor. 4. Nursing managers/supervisors will make rounds at least weekly on each shift to ensure that low air loss mattress covers are clean. Problems identified will be rectified immediately Results of rounds will be reported to facility PI Committee monthly for three months and thereafter as indicated by findings. Date of Compliance is ~~10/3/2010~~ 10/2/2010 MG	
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.	F 514	**F514** 1. Resident #4 was not negatively affected. Resident #4's chart has been flagged with label on inside cover to indicate Do Not Resuscitate (DNR) in accordance with facility practice on 8/20/10 by the nurse manager.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185290	A. BUILDING _____ B. WING _____	08/19/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY CARE AND REHABILITATION CENTER	1550 RAYDALE DR LOUISVILLE, KY 40219

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 12 The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined the facility failed to maintain clinical records on one (1) of thirty (30) sampled residents (Resident #4) in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The facility had a signed request from Resident #4 for a Do Not Initiate Cardiopulmonary Resuscitation (DNR) without the chart being flagged. The findings include: Record review of the clinical record for Resident #4 revealed the resident was admitted on 03/15/10 with diagnoses of Congestive Heart Failure, Atrial Fibrillation, Gastroesophageal Reflux, Hypertension, Diabetes Mellitus, and a Cardiovascular Accident. The facility provided and obtained a signed consent for a DNR signed by the legal representative on 05/08/10 and signed by the attending physician on 06/24/10. The chart and care plan were not flagged for a DNR status. Interview with the West Hall Unit Manager on 08/18/10 at 10:25am revealed the chart should have been followed up with when the DNR was	F 514	2. All residents with DNR request have the potential to be affected. The records of all residents with DNR orders were reviewed on 9/22/10 by the Health Information Manager to ensure that the chart is appropriately flagged. All residents' charts were found to be appropriately flagged. 3. All nurses have been re-educated by the nurse manager/supervisor on or before 10/2/10 on the importance of flagging charts of residents with requests for DNR and accompanying orders. 4. The Director of Social Services, Administrator and nurse managers will review the records of all new admitted residents within three days of admission to ensure if DNR requested, chart is flagged accordingly. Problems identified will be immediately rectified. Social Services Director or Health Information Manager will conduct monthly audit of DNR orders to ensure compliance. Results of audit will be reported to facility PI Committee monthly for three months and thereafter as indicated by findings for comments/suggestions. Date of Compliance is ~~10/3/2010~~ 10/2/2010 MB	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185290	A. BUILDING _____ B. WING _____	08/19/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY CARE AND REHABILITATION CENTER	1550 RAYDALE DR LOUISVILLE, KY 40219

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 13 signed by the legal representative on 05/08/10 and signed by the attending physician/advanced registered nurse practitioner on 06/24/10. She reported the chart should be flagged with the DNR status like the other charts on the unit. She reported she was unsure how this chart and care plan was missed and not accurate and complete in the areas to communicate the DNR status. She reported this was not acceptable.	F 514		

PRINTED: 09/23/2010
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185290	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	08/18/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY CARE AND REHABILITATION CENTER	1550 RAYDALE DR LOUISVILLE, KY 40219

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A Life Safety Code Survey was initiated and concluded on 08/18/2010 for compliance with Title 42, Code of Federal Regulations, 483.70 and found the facility to be In compliance with NFPA 101 Life Safety Code, 2000 Edition. No deficiencies were identified during this survey.	K 000		

RECEIVED
SEP 23 2010
OFFICE OF INSPECTOR GENERAL

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

NHA — Administrator — 9/23/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.